DISTRICT OF COLUMBIA
DOH Office of Adjudication and Hearings
825 North Capitol Street N.E., Suite 5100
Washington D.C. 20002

DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH Petitioner, v. D.C. FAMILY SERVICES and SHEILA A. GAITHER Respondents	Case No.: I-00-40084

FINAL ORDER

I. Introduction

On June 19, 2000, the Government served a Notice of Infraction upon Respondents D.C. Family Services, Inc. ("DCFS") and Sheila Gaither alleging that they violated 22 DCMR 3521.3, which requires a group home for mentally retarded persons to provide "habilitation, training and assistance to residents in accordance with the resident's Individual Habilitation Plan." The Notice of Infraction alleged that the violation occurred or was determined on May 17, 2000 at 1307 45th Place, S.E. and sought a fine of $500.

Respondents filed a timely plea of Deny, and I issued an order consolidating this case with Case No. I-00-40138, which involves the same Respondents. The order set a hearing date of July 21, 2000 in both cases. All parties appeared on that date. Carmen Johnson, Esq. represented the Government and Kathleen Deenihan, the Director of Health Services for D.C.

Family Services, appeared on behalf of Respondents. Due to the length of the hearing, I heard evidence on the allegations in Case No. I-00-40138 on July 21 and evidence on the allegations in Case No. I-00-40084 on August 25.

On August 29, 2000, I issued an order reopening the record and requiring Respondents to file copies of the Individual Habilitation Plans ("IHPs") for the residents at issue in both cases. Respondent filed both plans, and I permitted the parties to file additional evidence or written arguments related to those plans by September 18, 2000. The record closed on that date without the parties' filing any additional materials. Although I consolidated the cases before the hearing, the evidence has now made it clear that there is no factual overlap between them. Accordingly, it is appropriate to decide them with separate orders. I decided Case No. I-00-40138 in an order issued on October 22, 2001. This order decides Case No. I-00-40084.

Based upon the testimony of all the witnesses, my evaluation of their credibility, the documents introduced into evidence and the entire record in this matter, I now make the following findings of fact and conclusions of law.

II. Findings of Fact

DCFS operates a group home for mentally retarded persons at 1307 45th Street, S.E. Ms. Gaither is the Chief Executive Officer of DCFS. The allegations in this case concern the care received by one client at the facility, who will be referred to as Client #1.

Client #1 has been diagnosed as profoundly mentally retarded. He also suffers from various serious physical disorders, including seizure disorder, blindness and partial hearing loss. He is non-verbal and has no interactions with the other residents of the group home. A

psychological evaluation conducted in April 2000 and attached to his IHP estimated that his cognitive, adaptive/social and communication/language functioning all were at an age equivalent level of one year old or less. Client #1 previously had been able to walk, at least for short distances, but by the time of the events at issue in this case, he no longer did so and was confined to a wheelchair. He did not tolerate sitting in his wheelchair, however, and often would attempt to slide out of it, even if secured with a belt or harness. Such behavior presented a choking hazard, as the belt or harness could press on his neck as he attempted to slide to the floor.

Client #1 often engaged in self-injurious behavior, such as head banging and clothes tearing. DCFS attempted to have him wear a helmet full-time, to protect him from injury during head banging and seizures. Over the years, his tolerance for the helmet decreased significantly. He often would remove it and throw it across a room, sometimes after wearing it for only a few minutes. He sometimes would tear the straps off a helmet, rendering it useless and necessitating the ordering of a new helmet.

In October 1997, DCFS concluded that Client #1's placement in a group home was inappropriate, due to the profound level of his retardation and his growing inability to adapt to the group home program. At that time, it recommended to the Mental Retardation and Developmental Disabilities Administration ("MRDDA") that Client #1 be transferred to a nursing home and MRDDA agreed that he needed a nursing home level of care. For reasons that are not explained in the record, MRDDA had not arranged a nursing home placement by May 2000, the time of the events at issue in this case, even though DCFS made numerous requests for a transfer to be arranged.

On May 11 and 16, 2000, Sharon Mebane, an inspector employed by the Department of Health, visited the 45th Place facility to conduct an annual licensing inspection. On both occasions, Client #1 was not wearing a helmet when she arrived. The staff members on duty told her that Client #1 would not wear the helmet. He regularly would take it off and throw it across the room, endangering the safety of other residents and staff members. Due to that danger, the staff had decided at least several months earlier not to continue placing the helmet on his head. On both May 11 and May 16, the staff member on duty placed the helmet on Client #1's head when requested to do so by Ms. Mebane. On both occasions, he threw it off after only a few minutes and the staff member did not replace it.

During Ms. Mebane's May 16 visit, Client #1 was left alone in the living room for a time, as the staff member on duty went to another portion of the home. While unsupervised, Client #1 attempted to slide out of his wheelchair, but became entangled in the harness. Ms. Mebane called for the staff member who then re-positioned Client #1 in the wheelchair.

DCFS prepared an IHP for Client #1 annually. The most recent one was prepared in April 2000. Ms. Mebane testified that Client #1's IHP required that the staff replace his helmet whenever he removed it and that he have one-to-one supervision by a staff member at all times. The IHP filed in response to the order of August 29, 2000, however, does not support that testimony fully. The IHP does not contain any recommendation concerning one-to-one supervision. One of the goals specified in that plan is that Client #1 "will tolerate wearing his helmet at all times," IHP at 13, but neither the IHP nor the accompanying individual program plan specifies the methods to be used to achieve that goal. In particular, the IHP does not contain any recommendations concerning an appropriate response if Client #1 removes his helmet.

III. Conclusions of Law

Respondents are charged with violating 22 DCMR 3521.3, which requires group homes for mentally retarded persons to "provide habilitation, training and assistance to residents in accordance with the resident's Individual Habilitation Plan." Thus, to prove a violation of § 3521.3, the Government must show that Respondents failed to provide Client #1 with some form of habilitation, training or assistance specified in his IHP.[1] The Government's theory of the case is that Respondents failed to do so in two respects, *i.e.,* by not furnishing one-to-one supervision at all times and by not implementing measures designed to ensure that Client #1 would wear his helmet throughout the day.

As in Case No. 00-40138, there is no evidence of Ms. Gaither's involvement in any capacity in any of the acts or omissions that give rise to the Government's claims. Consequently, the charge against her will be dismissed. *DOH v. D.C. Family Services, Inc.*, OAH No. I-00-40138 at 6-7 (Final Order, October 22, 2001). Also, as noted above, no recommendation for one-to-one supervision appears in Client #1's IHP. The failure to provide one-to-one supervision on May 16, therefore, can not support a charge of violating § 3521.3. The issue that remains is whether the evidence concerning DCFS's efforts to encourage Client #1 to wear his helmet establishes a violation of § 3521.3.

The evidence demonstrates that Client #1 had not accomplished the goal of tolerating his helmet on the days of the inspector's visits. He was not wearing the helmet when she arrived,

[1] "Habilitation" is defined as "the process by which a person is assisted to acquire and maintain those life skills which enable him or her to cope more effectively with the demands of his or her own person and of his or her own environment and to raise the level of his or her physical, intellectual, social, emotional and economic efficiency." D.C. Code §6-1902(14), now codified as D.C. Code § 7-1301.03 (14) (2001 ed.); 22 DCMR 3599.1.

and the staff put it on his head only at her prompting. After he threw the helmet, the staff made no further efforts to put it back on, telling the inspector that they wanted to avoid the possibility of injury to others from a thrown helmet. Failure to achieve a goal established in an IHP is not necessarily a violation of § 3521.3, however. That section requires a group home to provide "habilitation, training and assistance," not to guarantee that a resident will accomplish every goal listed in the IHP. The holding in *DOH v. Community Multi-Services,* OAH No. I-00-40125 (Final Order, October 18, 2000), is appropriate here: "A resident's non-attainment of a goal identified in an individual habilitation plan is not necessarily a violation . . . . A group home operator that is providing appropriate training and other techniques designed to assist the resident in achieving a health or safety related goal is fully complying . . . , even if the resident has not yet achieved the goal." *Id.* at 5.[2]

Thus, Client #1's failure to achieve the goal of tolerating his helmet at all times is not sufficient proof by itself that Respondents violated § 3521.3. There also must be proof that DCFS was not providing him with appropriate training and assistance to meet that goal. The comments of the staff to Ms. Mebane provide such proof. Those comments show that they were not attempting to accomplish the goal at all, due to their concern that others might be injured when Client #1 threw the helmet. This practice had been in effect for several months, predating the most recent revision of the IHP in April, one month before the inspection. Although the staff's safety concerns may have been valid, a facility is not free simply to ignore a portion of an

[2] *Community Multi-Services* arose under 22 DCMR 3521.7(f), which specifically requires a group home operator to provide residents with habilitation and training in health care. The reasoning of that case is equally applicable to the more general requirement of 22 DCMR 3521.3 that a group home provide habilitation, training and assistance in accordance with an IHP.

IHP that it has adopted for a resident, even if its experience shows that the portion in question is inappropriate or unattainable. Instead, the facility must institute steps to modify the IHP.[3]

The undisputed evidence establishes that DCFS originally adopted the helmet toleration goal to protect Client #1 from the consequences of his head banging and seizures. DCFS was not free to eliminate that goal without modifying the IHP and providing for some alternative method of providing for his safety. A contrary result would encourage group home staff members to ignore IHP provisions that they might find inconvenient or difficult to implement. This would undermine the value of the IHP, a statutorily-mandated protection for all residents of group homes for mentally retarded persons. D.C. Code §§ 6-1922(b) and 6-1943 now codified as D.C. Code §§ 7-1303.02(b) and 7-1304.03 (2001 ed.).

DCFS understandably was frustrated by MRDDA's failure to move Client #1 to a nursing home for almost three years after MRDDA recognized that such a placement was necessary. DCFS, however, was the author of the IHP that recommended toleration of the helmet as a goal. DCFS, therefore, was responsible either to take appropriate steps to implement that goal or to initiate a change in the IHP. Because it did neither, it violated § 3521.3. A fine of $500 is authorized for that violation. 16 DCMR 3239.2(f).

[3] This does not mean that a group home must blindly follow a resident's IHP if its staff members are convinced that the plan would endanger the resident or others. Because an IHP can not be amended overnight, strict compliance with the plan is not required if the group home is making reasonably prompt efforts to modify a provision that has become inappropriate or dangerous. In this case, however, DCFS undertook no such efforts. Instead, it included the helmet toleration goal in the IHP in April, when its staff members already had concluded that encouraging Client #1 to wear his helmet at all times was both futile and dangerous.

V. Order

For the foregoing reasons, it is, this _____ day of _____, 2001:

ORDERED, that Respondent Sheila Gaither is **NOT LIABLE** for violating 22 DCMR 3521.3 as alleged in the Notice of Infraction; and it is further

ORDERED, that Respondent D.C. Family Services is **LIABLE** for violating 22 DCMR 3521.3 as alleged in the Notice of Infraction; and it is further

ORDERED, that Respondent D.C. Family Services shall pay a total of **FIVE HUNDRED DOLLARS ($500.00)** in accordance with the attached instructions within twenty (20) calendar days of the date of service of this Order (15 days plus 5 days service time pursuant to D.C. Code §§ 6-2714 and 6-2715, now codified as D.C. Code §§ 2-1802.04 and 2-1802.05 (2001 ed.); and it is further

ORDERED, that if Respondent fails to pay the above amount in full within twenty (20) calendar days of the date of mailing of this Order, interest shall accrue on the unpaid amount at the rate of 1 ½% per month or portion thereof, starting from the date of this Order, pursuant to section 203(i)(1) of the Civil Infractions Act, D.C. Code § 6-2713(i)(1), as amended by the Abatement and Condemnation of Nuisance Properties Omnibus Amendment Act of 2000, D.C. Law 13-281, effective April 27, 2001, now codified as D.C. Code § 2-1802.03(i)(1) (2001 ed.) ; and it is further

ORDERED, that failure to comply with the attached payment instructions and to remit a payment within the time specified will authorize the imposition of additional sanctions, including the suspension of Respondent's licenses or permits pursuant to D.C. Code § 6-2713(f), now codified as D.C. Code § 2-1802.03(f) (2001 ed.), the placement of a lien on real and personal

property owned by Respondent pursuant to D.C. Code § 6-2713(i), now codified as D.C. Code § 2-1802.03(i) (2001 ed.) and the sealing of Respondent's business premises or work sites pursuant to D.C. Code § 6-2703(b)(7), now codified as D.C. Code § 6-1801.03(b)(7) (2001 ed.).

/s/ 11/30/01

John P. Dean
Administrative Judge